

FILED SEP 19 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. CONRAD 29516

State File No.

BIRTH NO. 56300-55 REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 806

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY GREENE			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD				c. CITY OR TOWN SPRINGFIELD		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) 1 hr 40 min				e. STREET ADDRESS (If rural, give location) 1531 W. HOVEY			
d. FULL NAME OF HOSPITAL OR INSTITUTION BURGE HOSPITAL				e. STREET ADDRESS (If rural, give location) 1531 W. HOVEY			
3. NAME OF DECEASED (Type or Print) a. (First) ANGELIA		b. (Middle) DARLINE		c. (Last) WHITE		4. DATE OF DEATH (Month) (Day) (Year) SEPT. 10 1955	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED		8. DATE OF BIRTH SEPT. 10 1955	
9. AGE (In years last birthday) 1		10. MONTHS 40		11. BIRTHPLACE (City and State or Foreign Country) SPRINGFIELD, MISSOURI		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY —		13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME OPAL MAY WHITE	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME OPAL MAY WHITE		14. NAME OF HUSBAND OR WIFE X		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME OPAL MAY WHITE		ADDRESS SPRINGFIELD, MO.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Atelectasis INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours ANTECEDENT CAUSES Immature Birth DUE TO (b) 5 months DUE TO (c) Malnutrition of Mother II. OTHER SIGNIFICANT CONDITIONS Malnutrition of Mother Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) m.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 9-10-1955 to 9-10-1955 , that I last saw the deceased alive on 9-10-1955 , and that death occurred at 7:40 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Conrad, M.D.		23b. ADDRESS Springfield, Mo.		23c. DATE SIGNED 9-11-55		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9/12/55		24c. NAME OF CEMETERY OR CREMATORY EASTLAWN CEMETERY		24d. LOCATION (City, town, or county) (State) SPRINGFIELD, MISSOURI	
24e. DATE REC'D BY LOCAL REG. 9-13-55		24f. REGISTRAR'S SIGNATURE Edith Williamson		25. FUNERAL DIRECTOR'S SIGNATURE Edith Williamson		ADDRESS SPRINGFIELD, MO.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

THIS BODY WAS NOT EMBALMED

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.